FULL CIRCLE FARM
THERAPEUTIC HORSEMANSHIP

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Newport, NH 03773

603.863.1262
info@fcftherapeutic.org

fcftherapeutic.org

Date: _____

Dear Health Care Provider:

Your patient _____

(participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, we request that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopaedic
Atlantoaxial instability (include neurologic symptoms)
Coxarthrosis
Cranial defects
Heterotopic ossification/myositis ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic fractures
Spinal joint fusion/fixation
Spinal joint instability/abnormalities

Neurologic
Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II malformation/tethered coed/hydromyelia

Other
Age – under 4 years
Indwelling catheters/medical equipment
Medications – e.g. photosensitivity
Poor endurance
Skin breakdown

Medical/Psychological
Allergies
Animal abuse
Cardiac condition
Physical/sexual/emotional abuse
Blood pressure control
Dangerous to self or others
Exacerbations of medical conditions (e.g., RA, MS)
Fire settings
Hemophilia
Medical instability
Migraines
PVD
Respiratory compromise
Recent surgeries
Substance abuse
Thought control disorders
Weight control disorders

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Full Circle FarmTherapeutic Horsemanship

Physician's Statement

(This form must be signed by the participant's physician)

Participant: _____ DOB: _____ Height:_____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/prospective surgeries: _____
Medications: _____
Seizure type: _____ Controlled: Y N Date of last seizure: _____
Shunt present: Y N Date of last revision: _____
Special precautions/needs: _____
_____
Mobility: independent ambulation Y N assisted ambulation Y N wheelchair Y N
Braces/assistive devices: _____

For those with Down Syndrome: neurologic symptoms of atlantoaxial instability: ☐Present ☐Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Vision			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Full Circle Farm will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Full Circle Farm for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: (___) _____ License/UPIN Number: _____